PSYCHOLOGICAL DISORDERS

A Basic Introduction

Emotional First Aid Academy

PSYCHOLOGICAL DISORDERS

This unit is aligned to the following content and performance standards of the *National Standards for Psychology Curricula* (APA, 2011):

DOMAiN: iNDiViDUAL VARiATiON

STANDARD AREA: PSYCHOLOGiCAL DiSORDERS

CONTENT STANDARDS

After concluding this unit, students understand:
1. Perspectives on abnormal behavior
2. Categories of psychological disorders

CONTENT STANDARDS WiTH PERFORMANCE STANDARDS

CONTENT STANDARD 1: Perspectives on abnormal behavior

Students are able to (performance standards):
1. Define psychologically abnormal behavior
2. Describe historical and cross-cultural views of abnormality
3. Describe major models of abnormality
4. Discuss how stigma relates to abnormal behavior
5. Discuss the impact of psychological disorders on the individual, family, and society

CONTENT STANDARD 2: Categories of psychological disorders

Students are able to (performance standards):
1. Describe the classification of psychological disorders
2. Discuss the challenges associated with diagnosis
3. Describe symptoms and causes of major categories of psychological disorders (including schizophrenic, mood, anxiety, and personality disorders)
4. Evaluate how different factors influence an individual's experience of psychological disorders

DOMAiN: APPLiCATiONS OF PSYCHOLOGiCAL SCiENCE

STANDARD AREA: TREATMENT OF PSYCHOLOGiCAL DiSORDERS

CONTENT STANDARD

After concluding this unit, students understand:
Perspectives on treatment

CONTENT STANDARDS WiTH PERFORMANCE STANDARDS

CONTENT STANDARD 1: Perspectives on treatment

Students are able to (performance standards):
1. Explain how psychological treatments have changed over time and among cultures
2. Match methods of treatment to psychological perspectives

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CONTENTS

INTRODUCTION

It is common to find students new to psychology who believe the study of psychological disorders **is** psychology. These students are often disappointed to find out that it is only a small piece of what psychologists study and that they usually have to wait until the very end of the class to begin studying it.

Moreover, once they get to this unit, students bring with them preconceived notions regarding psychological disorders. More and more, these notions have been shaped by a student's own experience. Most all students know at least one person whose problem has been classified as a mental disorder and who is taking some sort of psychotropic medication to change the problem. Television advertisements, shows, their doctors, and other people they know have provided them with a lot of information, and for the most part they tend to believe what they have been told.

Unfortunately, much of what students have learned from these sources is not scientifically accurate. For example, most students believe "having a mental disorder" is a clear-cut thing. They believe you are either someone who "has one," or you are someone who "doesn't have one." They also tend to believe that explaining psychological disorders is far simpler than explaining any other kind of behavior. For example, they find it easy to accept it is impossible for us to determine with absolute certainty why someone would play basketball, but at the same time believe when someone acts depressed it is simply because of some neurochemical imbalance.

The facts of the matter are that people's problems are typically not categorical, but dimensional. People experience problems more or less over the duration of their lives. Sometimes and in some situations these problems interfere more than at other times and situations. Sometimes these problems get classified as "mental disorders," and sometimes they don't. In addition, the reasons why people experience problems are highly complex. Indeed, psychological disorders are at least as complex as why people experience or do anything else. It is important for students to understand the complexity of psychological disorders. There are many biological, psycho-

logical, and sociocultural factors involved in the development of psychological disorders. Understanding these different factors and their complexities is just as (if not more) important than memorizing the categorical names (diagnoses) of different problems. For this reason, it is important to emphasize the different models of abnormality and to avoid oversimplifying the complex nature of human problems.

The following Content Outline provides an overview of the history of understanding psychological disorders, followed by a summary of the major theoretical models used to explain them. The final section is a sampling of the major categorical descriptions of psychological disorders from the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition) (*DSM-5)* and the *International Classification of Diseases, Ninth Revision* (*ICD-9-CM*).

PROCEDURAL TIMELINE

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LESSON 2: CURRENT PERSPECTIVES

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Activity 2.2: On Being Sane in insane Places

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Activity 5.1: Connecting Media and Psychology

Activity 5.2: interesting Psychology information

CONTENT OUTLINE

LESSON 1

introduction and History

i. General

"Psychologically abnormal behavior" has been described as many things over the course of history including madness, insanity, craziness, lunacy, mental disorders, mental illnesses, psychopathology, maladjustment, behavioral disturbances, emotional disturbances, personal problems, etc. All of these descriptions are colored by the culture in which they arise and by the particular ideas people have for why people exhibit these problems.

There are at least as many definitions of psychological abnormality as there have been names for it. Because behaviors, emotions, cognitions, and adaptation are best described dimensionally, and because psychological abnormality is defined in most cases by these processes, it is very difficult to have a definition we can apply absolutely. It should come as no surprise, then, that there are no universally accepted definitions of psychological abnormality.

A. Comer (2014) states that most current definitions of abnormality include the ideas of deviance, distress, dysfunction, and dangerousness.

B. Rosenhan & Seligman (1995) also include ideas of observer discomfort, irrationality (to others), and violation of ideal standards.

C. The American Psychiatric Association's *Diagnostic and Statistical Manual* (*DSM-5)* describes some specific abnormal psychiatric conditions and defines these "mental disorders" as "… syndrome[s] characterized by clinically significant disturbance[s] in an individual's cognition, emotion regulation, or behavior that

reflects a dysfunction in psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above" (American Psychiatric Association, 2013, p. 20).

ii. Historical views of abnormality

A. Ancient times

Supernatural causes

The primary explanation for psychological disturbances in ancient times seems to have been supernatural causes. Egyptian, Chinese, and Hebrew writings all describe psychological disturbances as being caused by demons, and some of the earliest known treatments for the disorders were exorcisms, starvation, and maybe even trephination (Comer, 2014; Maher & Maher, 1985; Porter, 2003). Early explanations of abnormality in Indian, Chinese, and Egyptian cultures all refer to some sort of supernatural causes, along with imbalances in some sort of bodily fluids or forces.

B. Greece and Rome (500 BC to 500 AD)

Imbalances

Though Greeks such as Socrates and Homer were not immune from citing "the gods" as a potential source of madness, Hippocrates (460-377 BC) taught that illnesses had natural causes and that abnormality was the result of some sort of disease process resulting from imbalances of the four humours: black bile, yellow bile, blood, and phlegm (Porter, 2003).

C. Middle Ages (500 AD to 1350)

1. Europe

Supernatural explanations for problems again became very popular across Europe. This popularity was accompanied by a return to exorcisms and witch hunting as methods of eliminating problems. Dominican monks by the names of Kramer and Sprenger published the *Malleus Maleficarum* in 1486 (see

Mackay, 2009) as a sort of manual describing in dramatic detail the methods of identifying, examining, trying, and “treating” witches.

2. Middle East

The first hospital ward to treat madness was founded in Baghdad in the year 705. Some of the treatments at this hospital anticipated the development of “moral therapy” in Europe some 1,100 years later. In 1025, a Persian by the name of Ibn-Sina (Avicenna) completed a five-book encyclopedia of medicine known as *The Canon of Medicine* that takes a scientific approach to disease and whose descriptions and treatments of abnormality include but go far beyond the humoral explanations. This document has been cited as one of the most influential in the history of science (Sarton, 1952).

D. Renaissance (1400–1700)

1. Scientific thinking

Throughout Europe, scientific thinking gained momentum over supernatural explanations. Johannes Weyer (1515-1588) published a rebuttal to the *Malleus Maleficarum* and supernatural explanations of abnormality that makes the case that abnormalities might be considered diseases with natural causes. Because some of his work refuted supernatural causes, the church banned the book for centuries.

2. Development of asylums

Asylums, designed to house the “mad,” began to develop across Europe. One of the earliest of these was St. Mary of Bethlehem (“Bethlem” or “Bedlam”) in London. Bethlem is known to have housed people considered “mad” since the late 14th century. During that time, the ability to reason was the one faculty believed to differentiate people from other animals. Because people who were “mad” were considered to have lost their ability to reason, they were considered to be less than human and more like animals. Thus, institutions during these times were largely places that “maintained” patients by holding them away from the larger community. When attempts were made to actually treat people, the treatments were limited mostly to those focused on humoural imbalances (bleeding, purging, etc.). Patients were often chained in rooms and otherwise treated inhumanely (Andrews, Briggs, Porter, Tucker, & Waddington, 1997).

E. Late 18th century–mid-19th century

1. Moral therapy

   Philippe Pinel is credited with developing what he called "traitement morale." This idea was actually developed by one of Bicetre's former scrofula patients turned superintendent—Jean-Baptiste Pussin. The idea was essentially a switch from treating people like animals in chains to releasing them from their chains and treating them humanely and with respect. Pussin and Pinel first implemented this treatment at La Bicetre in Paris in 1793 and soon after instituted the change at the even larger La Salpetriere hospital for women also in Paris (Porter, 2003).

2. Moral therapy applied to asylums

   William Tuke is credited with establishing one of the first institutions based on the idea of moral therapy in York, England, in 1796. This institution, called The Retreat and commonly known as the "York Retreat," was built to be very much like a large Quaker home where patients would be treated with a combination of rest, talk, prayer, and manual work (Tuke, 1964).

3. Spread of moral therapy

   This sort of treatment spread throughout Europe and the United States, with many institutions developing along the lines of the York Retreat and moral therapy. Benjamin Rush (1745-1813) and Dorothea Dix (1802-1887) are two Americans known for the establishment of institutions (Rush) and the development of laws and reforms (Dix) in line with the notions of moral therapy.

F. Mid-19th century–early 20th century

1. Continued growth of mental hospitals

   Institutions for people exhibiting psychological abnormalities became increasingly large and increasingly unable to take good care of the people housed in them. The ideals of moral therapy gave way to the practicalities of treating large numbers of people in large institutions with relatively small numbers of staff. Once again individuals were not so much treated in these large "hospitals" as they were maintained (Scull, 1993).

2. Medical breakthroughs

   (a) New discoveries made in France and Germany linking syphilis to the development of general paresis (a devas-

tating brain disease that was quite prevalent and considered a form of madness until the early 20th century) led the way to a resurgence for the idea that biological factors played an important role in the development of psychological abnormalities.

(b) The development of arsphenamine and later penicillin in the treatment of syphilis drastically reduced the numbers of individuals developing general paresis. This success paved the way for other biological treatments of abnormalities, including removal of body parts (Cotton, 1921), insulin shock therapy (Sakel, 1927; see Shorter, 1997), electric convulsive therapy (Cerletti, 1956), and lobotomy (Moniz, 1935; see Tierney, 2000) and prescribing of chemicals like chlorpromazine (Laborit, 1949; see Swazey, 1974).

3. Psychological advances

Meanwhile in psychology, progress was being made in understanding all behavior, including abnormality. Individuals such as Freud (1933, psychoanalysis), Pavlov (1927, respondent conditioning), Skinner (1938, operant conditioning), Kelly (1955, role of cognition), Binswanger (1963, existentialism), Frankl (1958, role of meaning), and Rogers (1951, humanistic therapy) laid the foundations for modern psychological explanations of abnormality.

G. Mid-20th century–present

Developments continued in biomedical and psychological understanding and treatment of abnormality.

1. Biomedical advances

(a) Biological research to explain abnormality lagged far behind the use of biological treatments to treat it.

(b) Biological treatments continued to evolve largely through serendipitous discoveries of how medications (developed for altogether different purposes) seemed to affect behavior, affect, and cognition. Thus, in addition to treating problems like schizophrenia, drugs were developed to treat problems like mood disorders (tricyclic antidepressants for depression and lithium for bipolarity), anxiety disorders (benzodiazepines), and even childhood disorders like attention-deficit hyperactivity (methylphenidate).

(c) Though these treatments are popular today, the explanations for why these medications often work (and often don't work!) are still lacking.

(d) Technological advances in assessing brain structures and functions (e.g., EEG, PET, fMRI) have led to a better understanding of some of the brain correlates of abnormality.

2. Psychological advances

The psychological theories and therapies developed in the late 19th and early 20th centuries have continued to evolve with research to the present day. One major advance in the last half-century has been the connection of the cognitive and behavioral approaches to problems. This theoretical connection was made by psychologists such as Bandura (via social learning and social–cognitive theories), Rotter, and Mischel. In addition to those individuals, people such as Beck and Ellis were early leaders in developing treatments consistent with these ideas.

3. Advances in psychotherapies

In general, psychotherapies continued to evolve during the last half of the 20th century and continue to evolve to the present. Eysenck's (1952) landmark study of the ineffectiveness of psychoanalysis led to a massive increase in the research of the effectiveness of not only psychoanalysis but of all therapies. Thirty years later, Smith & Glass (1977) did a meta-analysis that supported the overall effectiveness of therapies across treatments and problems. Research also progressed in the domain of the "process" of therapy. This research was less concerned about which technique "worked the best" and more focused on the common factors all psychotherapies contain that make them all relatively effective. Though there is much support that common factors are more important than technique in predicting a successful outcome in therapy, this has not stopped research to determine "which therapy works best for which problems." This more prescriptive research has led to the notion of empirically supported treatments for various problems. Therapies whose stated treatment outcomes are more easily described objectively (e.g., cognitive behavior therapy) typically fare better than others (e.g. psychodynamic therapies) in these analyses.

Understanding problems

Because all theoretical models and treatments seem to account for some problems in significant ways better than others, all theoretical perspectives along with their treatments and associated research are alive today.

GO TO ACTIVITY 1

What Is Abnormal Behavior?

LESSON 2

Current Perspectives

i. Biomedical model

The **biomedical model** presumes that (like general paresis) all forms of abnormality are best understood as illnesses or diseases.

A. Causes of problems

1. Germs: Such as the bacterium causing syphilis and general paresis
2. Genes: Genetic mutations that cause illnesses either directly or by creating a biological vulnerability
3. Biochemistry: Imbalances in neurotransmitters
4. Neuroanatomy: Abnormal brain structures

B. Treatments

Treatments based on this model are mostly drug therapies that either kill the germs or theoretically restore the balance of neurotransmitters that are producing the illness.

C. Current status

This model is more prominent than other models today largely due to the availability of medical treatments, the ease of chemical treatment, and the idea that considering people exhibiting abnormality to be ill may reduce the stigma often associated with abnormality.

ii. Psychodynamic model

This model presumes unconscious psychological processes are responsible for abnormality.

A. Causes of problems

1. In the traditional Freudian sense, abnormality is a compromise between the structures of the personality. Individuals have unconscious needs or desires that have been repressed because they are unacceptable to the super ego. When too much of this instinctual desire is repressed, problems occur that symbolically represent these unexpressed desires.

2. In more recent terms, abnormality is the result of dissociated trauma. Individuals who experience severe emotional traumas that overwhelm their ability to handle them "dissociate" (mentally compartmentalize) the memory and emotion that would otherwise be overwhelming. This dissociated emotion seeks expression throughout the person's life, creating problems associated symbolically and experientially with the original traumas.

B. Treatments

With either explanation, treatments focus on making the unconscious conscious, or, as Freud said, "where id is, there shall ego be" (Freud, 1953), either by having the person experience the repressed instinctual desires or re-experience the traumas at the source of the repression/dissociation. In recent years, these treatments have been implicated in the development of "false memories" of childhood abuse. Though the legal implications of these false memories are recent, the issue of whether memories regained in therapy are historically true has been arduously debated since Freud's time.

C. Current status

The psychodynamic model is not nearly as pervasive in the understanding and treatment of abnormality as it was in the first half of the 20th century. However, psychodynamic explanations of problems like dissociative, somatoform, and personality disorders remain important, and similar explanations for other disorders, such as mood and anxiety disorders, are still relevant.

iii. Existential–humanistic model

A. General

These models hold that each individual has his/her own idiosyncratic experience of the world and that each person lives his/her life "as if" (Vaihinger, 1925) that experience is reality. There are many experiences of reality, and, therefore, there is no universal or culturally agreed-upon view that specific behaviors are a problem.

B. Causes of problems

Humanistic theories discuss this basic experience as based on a force of self-actualization that is an "instinctual drive to maintain and enhance the organism" (Rogers, 1951). They hold that abnormality is caused when an individual makes choices in life based on being accepted and approved of by significant others, rather than basing those choices on their own experience. Rather than taking responsibility for their own life course, abnormal individuals blame other people or external factors for their unhappiness and poor choices. This discrepancy is referred to as *incongruence* or *inauthenticity*. Additionally, abnormality can be caused when a person's life loses a sense of meaning based on the person's own experience (Frankl, 1958).

C. Treatments

Treatments focus on providing "empathy, genuineness and unconditional positive regard" so a person develops self-regard and can therefore learn to trust his/her own experience and develop his/her own sense of meaning. Rather than having their choices based on what will be most acceptable to others, people will then live their lives based on their own experience (authentic living).

D. Current status

This model is the least scientific of all the theoretical models and is thus the most prone to criticism. One of the major problems for supporters of this model has been finding a way of operationalizing concepts such as "experience" in a way that can be measured. In spite of this major problem, "current status" remains a legitimate model because it seems to explain some common problems (depression, anxiety, low self-esteem) in a way that seems most meaningful to many (Comer, 2014). Additionally, treatments based on this model have been successfully applied as an aspect of most all forms of psychotherapy.

iV. Cognitive–behavioral model

aA. Gener

This model combines the traditional behavioral model with the cognitive model.

B. Causes of problems

1. The **behavioral model** views abnormal behavior the same way it views any other behavior, as being determined by the environment via classical and operant conditioning. Problems are not viewed as symptoms of some other more basic difficulty, but as problems in and of themselves.

2. The **cognitive model** is based on a view similar to that of the philosopher Epictetus (84 AD), who said men are not disturbed by things, but by the way they think of them. In this view, it is irrational and/or maladaptive thinking that creates abnormality. This thinking can be in the form of more short-term cognitions such as expectations, appraisals, attributions or more long-term cognitions such as beliefs or life philosophies.

3. The **social cognitive model** is based largely on Bandura's work in observational learning and social cognitive theory and was one of the major efforts to unite and expand upon the behavioral and cognitive perspectives. His idea is that behavior (abnormal and otherwise) is reciprocally determined by combinations of environment, behavior, and person variables that are mostly cognitive in nature. The idea of reciprocal determinism along with concepts such as self-regulation and self-efficacy have led to many advances in the understanding and treatment of abnormality.

C. Treatments

1. Behavioral: Treatment of problems involves extinguishing unwanted behaviors and shaping and reinforcing desired behaviors via classical and operant conditioning.

2. Cognitive: Treatment of problems involves exposing the maladaptive and irrational patterns of thinking and replacing them with "the ironclad logic of rational thinking" (Ellis, Harper, & Powers, 1975).

3. Social cognitive: Treatments include modeling, building self-efficacy, and facilitating self-regulation of behavior.

D. Current status

The cognitive–behavioral perspective has many strengths. Among these are its basis in rigorous experimental science and the fact that therapies based on this theoretical model are relatively economical and very successful. For many of the most prevalent sorts of human problems (depression and anxiety disorders), cognitive behavior therapy has been shown to be as effective or superior to other forms of treatment (e.g., Hollon & Ponniah, 2010).

V. Sociocultural model

A. Gener

The **sociocultural model** looks at how greater sociological forces such as institutions, economies, and cultures shape individuals' behaviors, including their problems.

B. Causes of problems

The sociocultural model contends that individual problems are caused by the larger systems in which the individual is living. According to this model, nothing is wrong with the individual, per se. Abnormality is an outcome of an individual's living within systems that create problems. Individual problems are produced by factors such as poor family communication, racism, poverty, societal change, oppression, and dysfunctional institutions such as schools, governments, housing, churches, etc.

C. Treatment

Because the source of individual problems is beyond the individual level, individual therapy is of little use. Treatment from this perspective involves family therapies, work to eliminate societal ills such as poverty and racism, or initiatives to change how institutions such as schools and governments operate.

D. Current status

The main strength of this model is that it is the only theoretical model to view societal and cultural factors as causes of abnormality *in and of themselves*. The problems with this view are that it is based too heavily on case studies and epidemiological studies, and it does not explain well why only a minority of individuals living within the same problematic system develop abnormally.

Vi. Meta-theoretical models

A. General

Meta-theoretical models allow for research within all theoretical models to fit into the overall understanding and treatment of abnormality. Because psychological problems are complex, and because all theoretical models make substantial contributions to our understanding of problems, these meta-theoretical models are gaining in popularity. Two of the most prominent of them are the biopsychosocial model and the diathesis-stress model.

B. The **biopsychosocial model** suggests significant biological, psychological, and sociocultural factors are involved in the development and maintenance of abnormality. Though the relative role played by each set of factors may be more or less, depending on the problem and the individual, none of these factors should be overlooked when someone is trying to understand a person's problems.

C. The **diathesis-stress model** states that different biological factors produce a vulnerability to different forms of abnormality (diathesis) and that disorders develop when an individual experiences environmental stress exceeding that threshold of vulnerability.

GO TO ACTIVITY 2.1
Psychological Disorders and Perspectives in Psychology

Vii. Stigma and abnormal behavior

Stigma is when individuals with a certain characteristic or attribute become discredited and/or rejected by society as a result of that characteristic or attribute. When individuals' behaviors become classified as "mental disorders," this classification often discredits the individuals in the eyes of society and leads to their being rejected as individuals.

A. How does stigma relate to psychological problems?

An individual's abnormality or "having a mental disorder" or being "mentally ill" or "crazy," etc., can be one of those attributes that affects others' perception of that individual as well as the individual's own self-schema and can lead to rejection by those considered to not "have a mental disorder." One's cultural or ethnic background plays a major role in the stigmatization of mental illness and seeking help (e.g., African American, Latino/a, and Asian populations).

B. Consequences of having a problem classified

Being *labeled* with a mental disorder can affect how individuals view themselves and how others view them. Through social cognitive processes such as confirmation bias (Wason, 1960), self-serving bias (Miller, D. T., & Ross, 1975), and self-fulfilling prophecy (Merton, 1957), individuals can come to act more like the label that has been used to describe their problems.

C. Examples of uncovering and dealing with stigmas

1. Rosenhan's (1973) classic study "On Being Sane in Insane Places" supports how these processes occur even within professional mental health service communities.

2. One of the critiques of the *Diagnostic and Statistical Manual* (discussed more in depth later) is that its categorical system of classification promotes applying categorical descriptions to individuals that promote the labeling and stigmatizing of people exhibiting mental disorders.

3. Throughout history different sorts of efforts have been made to eliminate the stigmatic nature of diagnostic labels. One example is the viewing of everyone as mad in one way or another (Porter, 2003). The idea of the "wise fool" was another (Porter, 2003). Currently, groups such as "Mad Pride" encourage individuals to take pride in their madness and promote a removal of the stigmas associated with it.

GO TO ACTIVITY 2.2
On Being Sane in Insane Places

Viii. Prevalence of mental disorders

A. According to the World Health Organization, more than 450 million people exhibit some sort of mental disorder.

B. The 12-month prevalence rate of mental disorders of all kinds for adults in the U.S. is 26.2%. The comparative figure in Europe is 27%.

C. The 12-month prevalence rate of mental disorders of all kinds for children in the U.S. is 13.1% (8.6% classified as ADHD).

D. In 2007, there were about 35,000 suicides in the U.S. About 95% of these suicides were committed by individuals age 19 and over (CDC statistics).

iX. Financial impact of mental disorders

A. Mental illness is the leading cause of disability in children (Whitaker, 2010).

B. Mental disorders constitute more than 28% of the burden of disability in the U.S. and Canada (WHO statistics).

C. Expenditures for mental disorders constitute 6.2% of all health care expenditures ($100 billion in 2002) (NIMH statistics).

D. The average amount spent for mental health care in the U.S. is about $1,500 per person (NIMH statistics).

LESSON 3

Classification of Psychological Disorders

I. Classification systems

The *DSM-5* is the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition) (American Psychiatric Association, 2013). It is currently the most common means of classifying mental disorders used in the United States and, along with the *International Classification of Diseases, 10th Revision* (*ICD-10)* (World Health Organization, 1992), one of the most widely used classification systems for mental disorders around the world.

A. Contents of *DSM*

The *DSM-5* contains diagnostic criteria and codes for 19 specific categories of mental disorders and additional codes for conditions (often called V-codes) that may be a focus of clinical attention not considered mental disorders. These would include problems such as sibling relational problems, religious or spiritual problems, or extreme poverty.

B. Organization of *DSM*

The categories of the *DSM* are laid out in a general developmental fashion, with categories of disorders typically seen early in the lifespan described first, and those usually expressed later in the lifespan later. Likewise, disorders within categories are also presented in a somewhat developmental sequence.

C. The *International Classification of Diseases*

The *International Classification of Diseases (ICD)* is published by the World Health Organization. This manual is the most commonly used system for the classification of all diseases. It has a chapter devoted to the classification of mental and behavioral disorders. The current *DSM* uses coding from the current *ICD-9-CM* and the upcoming *ICD-10-CM,* and it has an organizational structure that reflects the anticipated structure of the *ICD-11,* due to be published sometime in 2017. Though the *DSM* and *ICD* organizational systems are not identical, there is and will continue to be a great deal of correspondence between the two systems.

II. Understanding classification

The classification of problems is difficult because the ways humans may experience and express problems are nearly limitless. Thus, classification provides descriptions of the most common ways humans express problems. These descriptions are best understood as prototypes (best examples of problems).

iii. Criticisms of the *DSM*

A. Biomedical orientation

There are many criticisms of the *DSM* as a classification tool. First among them is that the system is based on a biomedical model of problems (e.g., the term diagnostic).

B. Categorical vs. dimensional

Another major criticism concerns the categorical nature of classification. Though in reality individual problems are best described *dimensionally* (more or less) (Markon, Chmielewski, & Miller, 2011), the *DSM* is a categorical system (in or out). This categorical system is maintained because it is a traditional form of classification in medicine and because it is easier for clinicians to understand and use (American Psychiatric Association, 2013; Widiger & Shea, 1991).

The categorical nature of the *DSM* tends to increase inter-rater reliability, but is more questionable with regard to issues of validity. Further, it creates problems such as reification of the categories (making the categories seem like real entities), exacerbates problems such as secondary labeling, and increases the likelihood that a diagnostic label becomes integrated into the schemas of others and an individual's own self-schema becomes stigmatic.

Categories are **descriptions** of problems and **not explanations** for them. For example, bulimia nervosa *describes* a problem in which an individual binge eats and is involved in compensatory behavior. It does not mean that a person acts that way *because* of bulimia nervosa. Psychological disorders are complex and (as outlined previously) are explained in different ways by various theoretical approaches.

C. Modifications

The *DSM-5* attempts to address some of these issues by incorporating more dimensional aspects. This has been done in a variety of ways, for example by broadening some categories of disorders (e.g., autism spectrum disorder) and allowing for coding of severity of many problems along with the use of specifiers (e.g., major depressive disorder). Despite these additions, the *DSM* has essentially maintained its categorical nature (American Psychiatric Association, 2013).

IV. Important things to remember about the classification of psychological problems

A. Psychological disorders are classified only if the problems interfere with the person's life in some "clinically significant" (American Psychiatric Association, 2013) way. Typically, a mental health professional determines this clinical significance based on the degree of the individual's suffering and/or the reports of others close to the individual.

B. Psychological problems are complex and have biological, psychological, and sociocultural aspects. Thus, questions like "Is schizophrenia genetic?" denote an oversimplification of the complexities of the problems that together are known as schizophrenia.

C. Problems exist at different levels of severity, and the combinations of factors that might produce a problem for one person could be different from the factors that might produce similar problems in others.

D. There are also different factors that influence an individual's experience of psychological disorders.

1. The American Psychiatric Association (2013) makes it clear that psychological disorders "are defined in relation to culture, social and familial norms and values" (p. 14). Thus, it is important to understand the particular cultural background of an individual to understand the type and severity of the problem a person may be experiencing. Matsumoto & van de Vijver's (2011) description of "multicultural psychology" in part addresses the need to understand the impact culture may have on all behavior, including psychological disorders.

2. Additionally, people's different ages, cultural/ethnic backgrounds, and sexual orientation can relate to issues of mental health.

3. Factors such as culture and gender can have an impact on the way individuals experience problems. For example, a person's particular culture can influence how that person exhibits the problems they do. Examples of this may be the increase in numbers of people exhibiting dissociative identity disorders, eating disorders, or attention-deficit hyperactivity disorders in the United States (e.g. Hacking, 1999; Toro, et. al., 2005) or the existence of even more culture-specific disorders such as *susto*. Susto is an anxiety disorder found among people in Central and South America that is supposedly caused by having contact with supernatural beings or being the victim of black magic (Tan, 1980). It is important to remember that culture and gender are not specific single causes of psychological problems, but they can play a role in the development, experience, and expression of psychologi- cal disorders (American Psychiatric Association, 2013).

4. Social relationships and support have been shown to be protective factors against the development of psychological disorders (Cobb, 1976) and in the treatment of psychological disorders (Bryant, 2010).

LESSON 4

Psychological Disorders

i. Anxiety disorders

An underlying issue with all anxiety disorders is a normal fear response gone awry. Anxiety disorders are classified when the fear response triggered is out of proportion to the reality of the danger of a situation. Typically, individuals who experience this anxiety understand their fear is irrational but have a difficult time controlling this response. This irrational fear often leads to avoidance of situations or objects that interrupts a person's life in a significant way.

A. Examples of anxiety disorders

1. **Specific phobia** is an irrational fear of some specific object or situation.
2. **Agoraphobia** is literally "fear of the marketplace"; this is a person's fear of being out in some situation away from safety and being unable to escape should they experience overwhelming panic or in some other way become suddenly incapacitated.
3. **Social anxiety** is fear of being humiliated in front of others in one or more social situations.
4. **Panic disorder** is the experience of a sudden severe fear response in the absence of any sort of realistic threat. These "panic attacks" occur suddenly, are of brief duration, can be incapacitating, and lead to worry about experiencing more of them.
5. **Generalized anxiety disorder** is being worried and fearful of many different things, including health, finances, weather, family, etc. The worry is persistent and interferes significantly with the person's life.

A. Causes of anxiety disorders

1. Psychological: Classically conditioned fear responses and negatively reinforced avoidance (or other fear reducing) behaviors; irrational thinking, low self-efficacy, irrational appraisals, fear of negative evaluation, anxious apprehension; unresolved unconscious conflicts or traumas; incongruence, inauthenticity

2. Biological: Gamma-aminobutyric acid (GABA) inactivity; dysfunctional amygdala-hypothalamus-central grey matter-locus ceruleus circuit (Comer, 2014)

ii. Obsessive–compulsive and related disorders

A. Examples of obsessive–compulsive and related disorders

1. **Obsessive-compulsive disorder:** The key aspects of this disorder are repetitive thoughts; images or impulses that are unwelcome, produce anxiety, and are difficult to control (obsessions); and repetitive and often meaningless behaviors that are also difficult to control and that reduce anxiety associated with the obsessions (compulsions).

2. **Hoarding disorder:** A person with this disorder has persistent difficulty discarding possessions, regardless of their actual value, that leads to an accumulation of items that interfere with functioning.

3. **Body dysmorphic disorder:** This is a person's preoccupation with a perceived defect or flaw in physical appearance that seems insignificant to others. The person responds to this preoccupation by performing repetitive behaviors (such as checking, grooming, or comparing themselves to others).

A. Causes of obsessive–compulsive and related disorders

1. Psychological: Negative reinforcement of compulsive behaviors (for example, washing hands repeatedly is negatively reinforcing since it removes the anxiety of thinking about germs); ego-defense mechanisms of isolation, undoing, and reaction formation; irrational and negative thinking regarding undesired thoughts

2. Biological: Overactive orbitofrontal cortex-caudate nuclei-thalamic circuit

   Serotonin, glutamate, and dopamine appear to be the neurotransmitters most correlated with these disorders.

iii. Depressive disorders

A. Examples of depressive disorders

1. **Major depressive disorder (MDD):** Sad mood, loss of pleasure in activities, feelings of worthlessness, sleeping difficulties, lack of motivation lasting at least 2 weeks (This disorder

tends to be recurrent. Rather than being separate diagnostic entities, aspects of this disorder such as “with peripartum onset” and “with seasonal pattern” are now used as specifiers in the coding of major depressive disorder.)

2. **Persistent depressive disorder (PDD, formerly dysthymia):** Chronic depressive symptoms that have been experienced for at least 2 years (Because criteria for MDD are not contained in PDD, it is possible for someone to be classified as exhibiting both disorders.)

3. **Premenstrual dysphoric disorder:** Significant mood swings or depressive symptoms that occur in the week prior to the onset of menses and are greatly reduced or absent in the week postmenses

B. Causes of depressive disorders

1. Psychological: Negative schemas for self, ongoing experience, and future (cognitive triad); lack of reinforcement; regression and introjection after actual or symbolic loss of loved one; loss of meaning; incongruence

2. Biological: Some sort of dysfunction of a neurological circuit that includes the prefrontal cortex, hippocampus, amygdala, and Brodmann Area 25 (This circuit is rich in serotonin. Abnormal serotonin gene has been targeted as a potential predisposing factor.)

iV. Bipolar and related disorders

A. Examples of bipolar disorders

1. **Bipolar disorder:** For a person to be classified as exhibiting this disorder, the person must have exhibited a manic episode. A manic episode is characterized by persistently elevated, expansive, or irritable mood and includes such problems as inflated self-esteem, decreased need for sleep, flight of ideas, and distractibility that lasts for at least 1 week.

2. **Manic episodes** may include hallucinations and delusions. Depressive episodes may or may not be present.

B. Causes of bipolar disorder

1. Psychological: Manic-defense hypothesis—underlying processes similar to depression, but person denies and defends against them by acting in a manic way, perhaps due to need for approval by others

2. Biological: May be related somewhat to norepinephrine, serotonin, or GABA; abnormal ion activity within neurons; abnormal basal ganglia and cerebellum (Genes seem to play some role in creating vulnerability to these problems.)

V. Schizophrenia spectrum and other psychotic disorders

A. Examples of schizophrenia spectrum and other psychotic disorders

1. **Schizophrenia:** Schizophrenia consists of several problems associated with several psychological processes including delusions, hallucinations, disorganized speech, grossly disorganized behavior, and negative symptoms. These problems must persist for at least 6 months and be a significant negative change in the person's functioning.

2. **Delusional disorder:** The presence of one or more delusions (false beliefs a person holds in spite of evidence to the contrary and in spite of what others believe) (These delusions may be described in many ways, including erotomanic, grandiose, jealous, persecutory, or somatic.)

B. Causes of schizophrenia spectrum and other psychotic disorders

1. Psychological: External-personal attributions for negative events, operant conditioning of peculiar behaviors, attempting to make sense out of peculiar perceptual experiences, family stress and dysfunction

2. Biological: Biochemical abnormalities (dopamine and perhaps serotonin); abnormalities in frontal and temporal lobes and in brain structures such as the hippocampus, amygdala, and thalamus

GO TO ACTIVITY 4
An Assignment With Vignettes

LESSON 5

Psychological Disorders, Continued

i. Personality disorders

Personality disorders involve life-long patterns of maladaptive cognitions, thoughts, and behaviors that are both consistent (similar across situations) and stable (similar over time). These maladaptive patterns of behavior begin in childhood or early adolescence.

A. Examples of personality disorders

1. **Antisocial personality disorder** (includes problems also known as psychopathy and sociopathy): A pattern of disregarding and violating the rights of others that includes such problems as deceitfulness, impulsivity, aggressive behavior, recklessness, lack of conscience, irresponsibility, viewing others as prey

2. **Borderline personality disorder:** Instability with regard to identity, mood, relationships and includes problems such as impulsivity, feelings of emptiness, suicidal ideation, self-injurious behaviors

B. Causes of personality disorders

1. Psychological: Mistreatment in childhood and failure to establish positive loving relationships with parents, childhood trauma, lack of empathy, operant and classical conditioning, failure to learn from punishment, modeling, irrational beliefs, nonadaptive attributions

2. Biological: Genetic predispositions for maladaptive personality traits, slow autonomic arousal, abnormal frontal lobe activity

ii. Trauma and stressor-related disorders

A. Examples of trauma and stressor-related disorders

1. **Posttraumatic stress disorder:** A maladaptive reaction to actual or threatened death, serious injury, or sexual violence characterized by problems such as recurrent intrusive memories of the event, flashbacks, fear of stimuli associated with the event, negative changes in mood and ability to concentrate, irritability, and feelings of detachment

2. **Adjustment disorder:** A person's development of emotional or behavioral problems within 3 months after experiencing a stressful event

B. Causes of trauma and stress-related disorders

1. Psychological: Negative appraisals, fatalistic beliefs, apprehension, early childhood traumas, lack of social support, poor coping skills, low efficacy, limited self-capacities

2. Biological: Abnormal activity of cortisol and norepinephrine; abnormal activity in a circuit involving the hypothalamus and amygdala

iii. Dissociative and somatic symptom disorders

A. Examples of dissociative and somatic symptom disorders

1. **Dissociative identity disorder (formerly multiple personality disorder):** Presence of two or more distinct personality states, each present at different times and having their own cognitions, affect, and behavior

2. **Somatic symptom disorder:** Experiencing of somatic symptoms that are distressing and/or result in disruption of a person's life

3. **illness anxiety disorder:** Preoccupation with having or acquiring a specific illness, without experiencing somatic symptoms

4. **Conversion disorder:** Physical symptoms resulting in the loss of functioning not due to physical causes

5. **Factitious disorder (formerly Munchausen's syndrome):** Production of physical problems for the purpose of receiving medical attention

B. Causes of dissociative and somatic symptom disorders

1. Psychological: Keeping internal conflicts out of awareness (primary gain) and removing self from aversive events/activities (secondary gain), suggestion, self-hypnosis, repression of traumatic events, state-dependent learning

2. Biological: Some unspecified neurological predisposition

iV. Feeding and eating disorders

A. Examples of feeding and eating disorders

1. **Anorexia nervosa:** Refusal to maintain minimally normal body weight accompanied by an irrational fear of becoming obese
2. **Bulimia nervosa:** Binge eating accompanied by compensatory behavior that is either purging or nonpurging in nature
3. **Binge-eating disorder:** Binge eating without compensatory behavior

B. Causes of feeding and eating disorders

1. Psychological: Ego-deficiencies, perceptual disturbances, irrational beliefs, cognitive distortions
2. Biological: Dysfunctional hypothalamus
3. Sociological: Unreasonable societal standards, family environment, and communication

V. Neurodevelopmental disorders

These are disorders that develop early in the lifespan and are most often classified early in childhood.

A. Examples of neurodevelopmental disorders

1. **intellectual disability (formerly mental retardation):** Intellectual and adaptive functioning deficits
2. **Autism spectrum disorder (this disorder now includes what was formerly Asperger's disorder):** Significant problems with social communication and social interaction across many different social situations; small numbers of interests and activities
3. **Attention-deficit/hyperactivity disorder:** Significant and consistent pattern of inattention and impulsive behavior. This may be primarily an inattention problem, a hyperactivity/impulsivity problem, or a combination of both.

B. Causes of neurodevelopmental disorders

1. Psychological: Operant and classical conditioning, modeling, failure of self-regulatory systems, high levels of stress, family dysfunction, failure to develop a theory of mind

2. Biological: Neurotransmitter dysfunction (dopamine) in ADHD; genetic predispositions; abnormal frontal-striatal areas of the brain; prenatal difficulties; abnormalities in the brain such as in the limbic system, cerebellum, brain stem nuclei, frontal and temporal lobes

Vi. Substance-related and addictive disorders

Substance-related disorders involve the persistent maladaptive use of (a) specific substance(s). All disorders are substance-specific.

A. Examples of substance related and addictive disorders

1. **Alcohol use disorder:** Problematic use of alcohol indicated by behaviors such as craving, social problems, interference with work/school responsibilities, inability to stop using, physical problems
2. **Gambling disorder:** Problematic gambling behavior that leads to significant disruption of the person's life

B. Causes of substance-related and addictive disorders

1. Psychological: Operant and classical conditioning, modeling, stress, trauma, low efficacy, lack of coping skills, impulsivity
2. Biological: Genetic predisposition, abnormal GABA receptors, reward-deficiency syndrome
3. Sociocultural: Poverty, unemployment; dysfunctional families; societal value placed on substance use; availability

GO TO ACTIVITY 5.1
Connecting Media and Psychology

GO TO ACTIVITY 5.2
Interesting Psychology Information

ACTIVITIES

ACTIVITY 1

What is Abnormal Behavior?

From original TOPSS unit lesson plan

Procedure

This activity can be used to introduce the idea of abnormal psychology.

Ask students to individually write down three criteria they believe could be used to define abnormal behavior. Tell them they will be using their criteria to determine the relative mental health of the student described in the case study (below) you are going to give them. Provide them time to think critically about the case. Suggest the students use the prompt “Behavior might be considered psychologically disordered if it is ...”

Discussion

First, ask students to contribute ideas about psychologically disordered behavior. Write their ideas on the board or overhead with the goal of trying to develop some sort of class consensus. Your goal is to illustrate how difficult it is for us to agree on a workable definition of *psychologically*

disordered. As you cluster contributions from students, try to establish the general definition as follows.

Most accepted definitions of abnormality include the ideas of deviance, distress, dysfunction, and dangerousness (Comer, 2014).

Ask students if all these criteria should be involved to determine whether a behavior is psychologically disordered.

Second, distribute the case study (see below). Ask students to read it silently, then discuss with a partner whether or not Anne should be thought of as psychologically disordered. Opinions will differ. Ask several pairs to share their conclusions with the class and to support their position. Point out that behaving differently does not necessarily indicate poor mental health; we also need more information about Anne to make an informed decision. Students should come to understand the difficulties of determining abnormal behavior.

Finally, point out that the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association, along with the *International Classification of Diseases*, is an attempt to carefully categorize and describe mental disorders. *DSM-5* is used by psychologists and psychiatrists to do professionally what the students have attempted to do in this activity.

A Case Study

Anne is a 16-year-old girl living in a medium-sized city in the Midwest. Her family includes a mother, father, 14-year-old brother, and a great-aunt, who has lived with the family since Anne was 4. Anne is a junior at City High School and is taking a college-preparatory program. Her appearance is strikingly different from the appearance of the other girls in her class. She wears blouses which she has made out of various scraps of material. The blouses are accompanied by the same pair of overalls every day, two mismatched shoes, and a hat with a blue feather. She is a talented artist, producing sketches of her fellow classmates that are remarkably accurate. She draws constantly, even when told that to do so will lower her grade in classes where she is expected to take lecture notes.

She has no friends at school, but seems undisturbed by the fact that she eats lunch by herself and walks alone around the campus. Her grades are erratic; if she likes a class she often receives an A or B, but will do no work at all in those she dislikes. Anne can occasionally be heard talking to herself; she is interested in poetry and says she is “composing” if asked about her poetry. She refuses to watch television, calling it a “wasteland.”

This belief is carried into the classroom, where she refuses to watch videotapes, saying they are poor excuses for teaching. Her parents say they don't understand her; she isn't like anyone in their family. She and her brother have very little in common. He is embarrassed by Anne's behavior and doesn't understand her either. Anne seems blithely unaware of her apparent isolation, except for occasional outbursts about the meaninglessness of most people's activities.

ACTIVITY 2.1

Psychological Disorders and Perspectives in Psychology

Developed by

Scott Reed, MEd
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Review the diagnostic criteria of a particular disorder in the *DSM.* Select one of the criteria and relate the behavior to the different perspectives in psychology. Consider the course of the disorder including the onset, maintenance, and/or treatment.

Some possible disorders to consider: depression, alcohol use disorder, phobias, generalized anxiety, schizophrenia, obsessive–compulsive disorder, eating disorders, bipolar disorder, posttraumatic stress, or another of your choice.

Try to relate to these perspectives:

- Biomedical
- Psychodynamic
- Cognitive
- Behavioral
- Humanistic
- Sociocultural

ACTIVITY 2.2

On Being Sane in insane Places

Developed by

Nancy Diehl, PhD
Hong Kong International School, Tai Tam, Hong Kong

The purpose of this activity is to further understand issues related to defining psychological disorders in context, considering aspects of labeling and treatment, using Rosenhan's classic study as a backdrop. This also addresses contemporary issues of making a referral. Students should work in small groups of five to seven.

Part 1

Students read the original or a summary of Rosenhan's classic experiment (Rosenhan, 1973) "On Being Sane in Insane Places."

Part 2

Hold a class discussion. Topics may include:

- Research design including selection of participants
- Typical behavior of psychiatric patients
- Confirmation bias
- The long-term impact of labeling
- Historical context (This may affect categories and labeling in early to mid-1970s America. Of note, the publication date of Rosenhan's work is the same year homosexuality was removed from the *DSM.)*

Part 3

Students discuss the related issue regarding how to refer someone with disordered behavior to seek evaluation and/or treatment. Using acronym REFER (Van Raalte & Brewer, 2005), discuss each step:

R—Recognize a referral is needed.

E—Explain the referral process.

F—Focus on feelings.

E—Exit if emotions are too intense.

R—Repeat and follow up as needed.

Discuss effectiveness of a referral attempt as framed above.

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ACTIVITY 4

An Assignment With Vignettes

Write a vignette, a short story, about a person who has been diagnosed with one of the disorders from the lesson. Include the onset of the disorder, how it is affecting the person's life, and how the person is coping with the disorder.

The students can share the vignettes with class members and see if they can identify some of the relevant characteristics of the disorder. Disorders may include: agoraphobia, generalized anxiety disorder, obsessive–compulsive disorder, major depressive disorder, bipolar disorder, schizophrenia, antisocial personality disorder, borderline personality disorder, post-traumatic stress disorder, dissociative identity disorder, factitious disorder, anorexia nervosa, bulimia nervosa, autism spectrum disorder, attention-deficit/hyperactivity disorder.

Sources

American Psychological Association
http://www.apa.org

National Institute of Mental Health
http://www.nimh.nih.gov

National Alliance on Mental Illness
http://www.nami.org

ACTIVITY 5.1

Connecting Media and Psychology

The purpose of this assignment is to help students to find connections between what they experience in their lives and the field of psychology. This may also be an out-of-class assignment.

Student instructions

(a) **Select** a newspaper or magazine article, song lyrics, drawrings, or YouTube video that is meaningful or interesting to you relating, in some meaningful way, to a psychological disorder. The article, song, drawing, or video you select is your "**media source**."

(b) **Re-read or review** your media source and type a paper or create a presentation in which you first **describe** your media source. What is your media source about? What is interesting or meaningful about it? Why did you choose this particular media source? Feel free to quote the essential characteristics with proper citations.

(c) **Explain** the connection between the media source and relevant terms covered in the textbook. Be as detailed as possible. You cannot do this from memory. You must be specific about your media source and the text terms. Use **psychology terms** (and underline them) and include their **definitions**. Where possible, consider the perspective taken in the article, song, drawing, or video (e.g., biomedical, psychodynamic, cognitive, behavioral, humanistic, sociocultural).

(d) **Submit** your media source (or the web address of your source or movie or song lyrics) with the paper or on the presentation day.

ACTIVITY 5.2

interesting Psychology information

The purpose of this assignment is to familiarize students with the American Psychological Association, which has a website that provides scientifically based, interesting, and important info related to psychology, including psychological disorders. Students will be directed to the *Monitor on Psychology* magazine to select an article.

Student instructions

Go to this website for the *Monitor on Psychology* monthly magazine published by APA: http://www.apa.org/monitor/.

(a) **Select** an article to read focused on issues related to psychological disorders in general or specifically or issues that relate to the diagnosis, care, treatment of people with psychological disorders, family or caregiver concerns, or more generally regarding the *Diagnostic and Statistical Manual of Mental Disorders* (it can be from a previous issue—see link at the side of the webpage).

(b) Read your article and type a paper in which you first **summarize** the article.

(c) What is the most important idea in the article? Explain your answer. Be as detailed as you can be.

(d) Explain the connection you see between the most important idea in the article and concepts in the textbook. Be as detailed as possible. Use **psychology terms** (and underline them) and include their **definitions**. If a topic has not yet been covered in class, look it up and read the

relevant section(s). Do not limit your connections to the chapter on psychological disorders, but make connections with previous sections on topics such as research design, stress, biology of the mind, nature–nurture, etc.

(e) Submit a **hard copy of your article** along with your paper.

CRITICAL THINKING AND DISCUSSION QUESTIONS

CRiTiCAL THiNKiNG ON PSYCHOLOGiCAL DiSORDERS

Critical Thinking Exercise for Lesson 1

As explained in the unit, defining the term *mental disorder* is complex. Comer (2014) suggested most accepted definitions include the ideas of deviance, distress, dysfunction, and dangerousness. Demonstrate your understanding by giving one example of a behavior that reflects each "D." How might historical context and culture affect these decisions?

Critical Thinking Exercise for Lesson 2

Consider the perspectives in psychology: psychodynamic, cognitive, behavioral, humanistic, sociocultural, and biological. Given what you've learned thus far, does any one or more perspective(s) resonate with you? Which? Why?

What steps can high school students take to lessen the stigma often associated with psychological disorders? What steps can be taken by various community leaders?

Critical Thinking Exercise for Lesson 3

Personality disorders have been a controversial aspect of the *DSM. DSM-5* described three clusters, with specific disorders falling under each of three categories: anxiety related, eccentric, and dramatic/impulsive. In the

development of *DSM-5,* there was much debate about changing these categories, but ultimately they remained the same. What are some of the challenges categorizing these disorders? What changes do you foresee for next *DSM* edition?

Critical Thinking Exercise for Lesson 4

Apply the learning perspective using concepts in classical conditioning and operant conditioning (e.g., unconditioned stimulus, reinforcement, punishment) to describe how a teenager may have developed a school phobia. Consider how the reasons for the initial driving force of the behavior may be different from the reasons for maintaining the behavior.

Critical Thinking Exercise for Lesson 5

When exposed to trauma, most people do not develop posttraumatic stress disorder (PTSD). Discuss factors that might influence who develops PTSD and who does not.

DiSCUSSiON QUESTiONS

Discussion Questions for Lesson 1

Changes in the treatment of people with abnormal behavior have coincided with social change and medical understanding. What changes do you think might happen in the next 10–20 years? How might technological advances inform or shift current understanding of abnormality?

There is a much smaller percentage of the population in mental institutions in America since the philosophy of deinstitutionalization started in the 1970s. Why do you think so many fewer people are now institutionalized? What were some of the problems associated with the release of so many patients? What are some ways those are being dealt with now?

Discussion Questions for Lesson 2

The biopsychosocial model suggests the interaction of many different kinds of factors leads to the development of mental disorders. Describe evidence that emphasizes environmental causes for mental disorders. Describe evidence for biological causes of mental disorders. How might these interact?

What might parents of a child with abnormal behavior consider as short-term or long-term effects of labeling? What might parents consider as benefits?

From each of the different perspectives, how do early experiences (e.g., significant levels of stress) contribute to likelihood of developing a disorder?

Discussion Question for Lesson 3

What are the pros and cons of classifying abnormal behaviors with a system such as *DSM* or *ICD?*

Discussion Questions for Lesson 4

In what ways does major depressive disorder differ from “the blues”?

Compare and contrast the biological and behavioral views of anxiety disorders and discuss how differences between the two views might be reconciled.

Discussion Questions for Lesson 5

People unfamiliar with the study of abnormal behavior sometimes confuse “multiple personality” with schizophrenia. How would you explain the differences?

In what ways do personality disorders differ from other psychological disorders? In what ways are they similar?

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